

12285

CERTIFICATE OF DEATH

12296

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY Chester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural		c. LENGTH OF STAY IN 1b Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alson Bappit Arnold		4. DATE OF DEATH Sept. 15 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-1880
9. AGE (In years first birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Ret. Own Farm		11b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (County & State, or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Weston Arnold		14. MOTHER'S MAIDEN NAME Zeruah Bappit	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 262-80-8639	
17. INFORMANT Mrs. Alson Arnold		Address Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO (b) Septicemia DUE TO (c) Cerebro-vascular Accident			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 14, 1967 , to Sept 15, 1967 , that (I) (we) last saw the deceased alive on Sept. 14, 1967 , and that death occurred at 3:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Toy G. Davis		22b. DATE SIGNED SEP. 18, 1967	
22c. PHYSICIAN'S NAME (Type) Toy G. Davis M.D.		22d. ADDRESS Oxford Penna.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-18-1967	23c. NAME OF CEMETERY OR CREMATORY Friends Cem.	23d. LOCATION (City or Town) (County) (State) Calvert Cecil Md.
24. FUNERAL DIRECTOR Thomas E. McMillan		25a. REC'D BY REGISTRAR SEP 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12345

Gecil

Chester

Tennis

Muriel

St. Stephen

Monahan

Richard and Muriel

Oliver's Manor Nursing Home

A. F. D. I

Arnold

Baptist

Alison

Sept.

12

8-23-1240

Male White

U.S.A.

Vermon

Mr. Own

Partner

Baptist

Vermon

Arnold

Wesson

Same as above

802-2-3339 Mr. Alison Arnold

*Urgent
The President
Cordell H. Ford*

*1944
Ford
2/10*

*2/10/67
2/10/67*

Calvert Farms

N.D.

John B. Davis

Cal.

Calvert

Calvert

7-10-1967

Calvert

Richard and Muriel

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12286

12297

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON Md.		c. LENGTH OF STAY IN lb 2 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last KATHRYN P. Benson				4. DATE OF DEATH Month Day Year Sept. 19 1967			
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 22, 1878	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) P.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM A. PYLE				14. MOTHER'S MAIDEN NAME MARY A. HANNUM			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address J. HOWARD PYLE CHESAPEAKE CITY, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Respiratory Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic arterio-sclerotic heart disease DUE TO acute (c) acute							INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct 19 , 19 36 , to Sept 19 , 19 67 , that (I) (we) last saw the deceased alive on Sept 19 , 19 67 , and that death occurred at 2:45 PM , from causes and on the date stated above.							
22a. SIGNATURE Henry J. Davis			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/19/67		
22c. PHYSICIAN'S NAME (Type) HENRY J. DAVIS MD			22d. ADDRESS CHESAPEAKE CITY MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-23-67		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) CHESAPEAKE CITY Cecil Md.	
24. FUNERAL DIRECTOR Pippin Funeral Home			Address ELKTON MD		25a. REC'D BY REGISTRAR SEP 25 1967		25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS

622

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, this 1st day of May, 1901.

Attest my hand and seal of office, this 1st day of May, 1901.

NOTARY PUBLIC FOR THE STATE OF TEXAS

My commission expires on the 1st day of May, 1902.

My office is located at the corner of Main and Elm Streets, Dallas, Texas.

My term of office is for two years.

My salary is \$100.00 per annum.

My bond is in the sum of \$100.00.

My qualification is as follows:

I am a native-born citizen of the United States.

I am a resident of the State of Texas.

I am a member of the State Bar.

I am a member of the State Association of Notaries Public.

I am a member of the State Association of Attorneys.

NOTARY PUBLIC FOR THE STATE OF TEXAS
My commission expires on the 1st day of May, 1902.
My office is located at the corner of Main and Elm Streets, Dallas, Texas.
My term of office is for two years.
My salary is \$100.00 per annum.
My bond is in the sum of \$100.00.
My qualification is as follows:
I am a native-born citizen of the United States.
I am a resident of the State of Texas.
I am a member of the State Bar.
I am a member of the State Association of Notaries Public.
I am a member of the State Association of Attorneys.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12287

CERTIFICATE OF DEATH

12298

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>		d. STREET ADDRESS <u>071</u>	
3. NAME OF DECEASED (Type or print) <u>HENRY J. BORGER</u>		4. DATE OF DEATH Month <u>SEP</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/3/1919</u> AGE (In years last birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOATING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY BORGER</u>		14. MOTHER'S MAIDEN NAME <u>ALETHA LOUIBERSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>109-124413</u>	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY DISEASE</u> DUE TO <u>CHRONIC ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u>ALTE ATTACK</u> DUE TO <u>SEVERAL YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC ARTERIOSCLEROSIS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 17</u> , 19 <u>67</u> , to <u>SEP 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 5</u> , 19 <u>67</u> , and that death occurred at <u>11:30 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>9/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY V. PAULS MD</u>		22d. ADDRESS <u>CHESAPEAKE CITY MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-14-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>CHESAPEAKE CITY MD</u>	
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>ELKTON, MD</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>SEP 13 1967</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12288

CERTIFICATE OF DEATH

12299

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Aikin Ave.</u>		d. STREET ADDRESS <u>Aikin Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Kathryn</u> Middle <u>Geary</u> Last <u>Calvert</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1886</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Geary</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Greenlee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Zelma Calvert, Perryville, Maryland.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>334X</u> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Sclerosis</u> DUE TO (c) <u>Cerebral Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Perryville, Cecil, Maryland</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>November 19, 1962</u> to <u>Sept 22, 1967</u> that (I) (we) last saw the deceased alive on <u>Sept 22, 1967</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Clarence I. Benson</u>		22b. DATE SIGNED <u>Sept. 23-67.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Clarence I. Benson M.D.</u>		22d. ADDRESS <u>Port Deposit, Maryland.</u>	
23a. BURIAL, CREMATION, REMOVAL, etc. <u>Buried</u>		23b. DATE THEREOF <u>Sept 25, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grave Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Aberdeen, Maryland.</u>	
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son, Perryville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of the person or organization 2. Address 3. City 4. State 5. Zip		6. Date 7. Time	
8. Subject 9. Description of the event or activity		10. Remarks	
11. Name of the person or organization 12. Address 13. City 14. State 15. Zip		16. Date 17. Time	
18. Subject 19. Description of the event or activity		20. Remarks	
21. Name of the person or organization 22. Address 23. City 24. State 25. Zip		26. Date 27. Time	
28. Subject 29. Description of the event or activity		30. Remarks	
31. Name of the person or organization 32. Address 33. City 34. State 35. Zip		36. Date 37. Time	
38. Subject 39. Description of the event or activity		40. Remarks	
41. Name of the person or organization 42. Address 43. City 44. State 45. Zip		46. Date 47. Time	
48. Subject 49. Description of the event or activity		50. Remarks	
51. Name of the person or organization 52. Address 53. City 54. State 55. Zip		56. Date 57. Time	
58. Subject 59. Description of the event or activity		60. Remarks	
61. Name of the person or organization 62. Address 63. City 64. State 65. Zip		66. Date 67. Time	
68. Subject 69. Description of the event or activity		70. Remarks	
71. Name of the person or organization 72. Address 73. City 74. State 75. Zip		76. Date 77. Time	
78. Subject 79. Description of the event or activity		80. Remarks	
81. Name of the person or organization 82. Address 83. City 84. State 85. Zip		86. Date 87. Time	
88. Subject 89. Description of the event or activity		90. Remarks	
91. Name of the person or organization 92. Address 93. City 94. State 95. Zip		96. Date 97. Time	
98. Subject 99. Description of the event or activity		100. Remarks	



This document is a copy of a document
 filed in the records of the
 Department of the Interior
 Bureau of Land Management
 Washington, D.C. 20240
 Date of filing: 10/1/80
 File number: 100-100000-100000

FOR STATE
HEALTH DEPT

12289

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12300

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northeast (elkton) c. LENGTH OF STAY IN lb Northeast d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northeast d. STREET ADDRESS 35 S. Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle PEARL Last CLARK		4. DATE OF DEATH Month September Day 21, Year 19 67	
5. SEX Female	6. COLOR OR RACE Indian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1909
9. AGE (In years lost birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY V.F.W.	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. Clark		14. MOTHER'S MAIDEN NAME Mary Wyatt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Virginia Hughey		Address Milton, Del.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 22. DATE SIGNED 9/22/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-25-67	23c. NAME OF CEMETERY OR CREMATORY North East Methodist	23d. LOCATION (City or Town) (County) (State) North East Cecil Md.
24. FUNERAL DIRECTOR Paul R. Crouch Grant Funeral Home		ADDRESS Box 22 North East, Md.	25a. REC'D BY REGISTRAR SEP 26 1967 25b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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North West (London)

Union (London)

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William O. Clark

V.P.M.

Belmont

Mr. Wright

Mr. Wright, Belmont, N.Y.

International Association of

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
12200									
12301									
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown				
c. LENGTH OF STAY IN 1b 13 days					d. STREET ADDRESS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last JEAN R. CROUCH					4. DATE OF DEATH Month Day Year Sept. 7 19 67				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21, 1919		9. AGE (In years last birthday) 48 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Mercer Co. W.Va.		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Arthur Johnson					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 234-32-5701		17. INFORMANT Frank R. Crouch Address Charlestown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastatic carcinoma. 1750 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Papillary carcinoma of the ovary DUE TO (c) 16 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from Sept. 1966, to Sept. 1967, that (1) (we) last saw the deceased alive on Sept. 6 1967, and that death occurred at 3 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Jay S. Barnhart Jr.					22b. DATE SIGNED Sept 8, 1967				
22c. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.					22d. ADDRESS 4 Mauldin Ave., North East, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9-10-67		23c. NAME OF CEMETERY OR CREMATORY Hart's Cemetery		23d. LOCATION (City, town or county) (State) Cecil County, Maryland		
24. FUNERAL DIRECTOR Paul R. Crouch Grant Funeral Home					25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles J. [Signature]				



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1902

Union Hospital

THOMAS H. CHURCH

Yonkers

Yonkers

Yonkers

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

10/18/67

12291

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12302

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elkton		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital			d. STREET ADDRESS R.D. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) RILEY ALFRED DICKENS			4. DATE OF DEATH Month Sept. Day 30 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1916		9. AGE (In years last birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timber Cutter		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) South Dakota	
13. FATHER'S NAME Emanuel Dickens			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 192-12-6858		17. INFORMANT Anna Pauline Dickens Address Box 562 Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Contact with R.R. high voltage transformer			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:30 p.m. 9-30-1967		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pa. R.R. power pole		20f. (City or town) (County) (State) Elkton Cecil Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Tillman D. Johnson M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 9-30-67	
EXAMINER'S NAME (Type) Tillman D. Johnson M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) 123 Singler Ave., Elkton	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-5-67		23c. NAME OF CEMETERY OR CREMATORY North East Methodist	
24. FUNERAL DIRECTOR Grant Funeral Home		ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR OCT 3 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



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CERTIFICATE OF DEATH

12303

12292

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Iron Hill Road		d. STREET ADDRESS Iron Hill Road	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE A. ELY		4. DATE OF DEATH Month Day Year 9-7-67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-8-1898
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	
11. BIRTHPLACE (County & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwin S. Ely		14. MOTHER'S MAIDEN NAME Flora Fenn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. 221-24-4314	
17. INFORMANT Margaret B. Ely		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X DUE TO Massive intra-abdominal and right hypochondri recurrence of clear cell carcinoma of the right (b) kidney. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March, 1966, to Sept, 1967, that (I) (we) last saw the deceased alive on July 24, 1967, and that death occurred at 4 A.M. from causes on the date stated above.			
22a. SIGNATURE C. R. Donoho C.R. Donoho		22b. DATE SIGNED 9-8-67	
22c. PHYSICIAN'S NAME (Type) C. R. Donoho, M. D.		22d. ADDRESS Newark, Delaware	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-9-67	23c. NAME OF CEMETERY OR CREMATORY Lower Brandywine	23d. LOCATION (City or Town) (County) (State) Wilmington, Dela. N.C.
24. FUNERAL DIRECTOR William J. Narwick		25a. REC'D BY REGISTRAR DATE SEP 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12304

12293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS Haines Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JUNIOR BILLY FRAZIER		4. DATE OF DEATH Month Day Year September 29, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1928
9. AGE (In years lost birthday) 39 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Relief Man Paint Shop Chrysler Motors Worth West Va.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Albert Frazier		14. MOTHER'S MAIDEN NAME Emma White	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 231-24-5494	
17. INFORMANT Mrs. Junior Frazier		Address Rising Sun, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO (b) 816.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (Partial)
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Passenger in auto-auto collision	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:00 9-29-19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) highway (partial)		20f. (City or town) (County) (State) CALVERT CECIL MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		22. DATE SIGNED September 29, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-2-1967	
23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.		23d. LOCATION (City or Town) (County) (State) Colora Cecil Md.	
24. FUNERAL DIRECTOR Richard L. Goodie		25a. REC'D BY REGISTRAR OCT 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12294		CERTIFICATE OF DEATH	
12305			
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 11 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1658 Euclid St., N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Herman A. GIVENS		4. DATE OF DEATH Month September Day 3 Year 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 23 10
9. AGE (In years lost birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 5 Ooys 7 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Labor	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Givens		14. MOTHER'S MAIEN NAME Florence Blackwell	
15. WAS DECEASED EVER IN U.S. ARMOE FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW II		16. SOCIAL SECURITY NO. 231-32-25-64	
17. INFORMANT VA Hospital Records - Perry Point, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. OEAH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Aspiration Type DUE TO Carcinoma of Pancreas with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. generalized carcinomatosis DUE TO (b) At least 6 months DUE TO (c)			
PART II. OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIOENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II af item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURREO While <input type="checkbox"/> Not While <input type="checkbox"/> ot work <input type="checkbox"/> ot work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8 23 67 , 19 pm to 9 3 67 , 19 pm , and that death occurred at 11:35 M, from causes on and on the date stated above.			
22a. SIGNATURE S. Goldgraben		22b. DATE SIGNED 9-4-67	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.		22d. AOORESS VA Hospital - Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9/8/1967	
23c. NAME OF CEMETERY OR CREMATORY Harmony		23d. LOCATION (City or Town) (County) (State) Landover, Maryland	
24. FUNERAL DIRECTOR Walbert Simon		25a. REC'D BY REGISTRAR SEP 6 1967	
Jarvis Funeral Home 1432 You St., N.W. Wash. DC		25b. REGISTRAR'S SIGNATURE Charles Judge	

UNITED STATES DEPARTMENT OF JUSTICE

1963

INVESTIGATION OF CONSPIRACY

1963

Memorandum

TO :

FROM :

SUBJECT :

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, North East					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, North East									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.D. 2					d. STREET ADDRESS R.D. 2									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First Middle Last Emma Powell Gray					4. DATE OF DEATH Month Day Year Sept. 14 1967									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1879		9. AGE (In years last birthday) 88 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) New Castle Co. Del.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William R. Powell					14. MOTHER'S MAIDEN NAME Elizabeth Iofland									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 221-30-8096		17. INFORMANT Mrs. Linda Dolinger			Address R.D. 2 North East, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Senile and arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)														
21. I certify that (1) (this hospital) attended the deceased from Aug, 1967, to Sept, 1967, that (1) (we) last saw the deceased alive on Sept 6, 1967, and that death occurred at 11 AM, from the causes and on the date stated above.														
22a. SIGNATURE Jay S. Barnhart Jr.					22b. DATE SIGNED 9-14-67									
22c. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.					22d. ADDRESS 4 Mauldin Ave., North East, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9-16-67		23c. NAME OF CEMETERY OR CREMATORY Silverbrook			23d. LOCATION (City, town or county) (State) Wilmington Del.						
24. FUNERAL DIRECTOR Paul R. Crouch Grant Funeral Home					25a. REC'D BY REGISTRAR SEP 18 1967					25b. REGISTRAR'S SIGNATURE James J. Judge				

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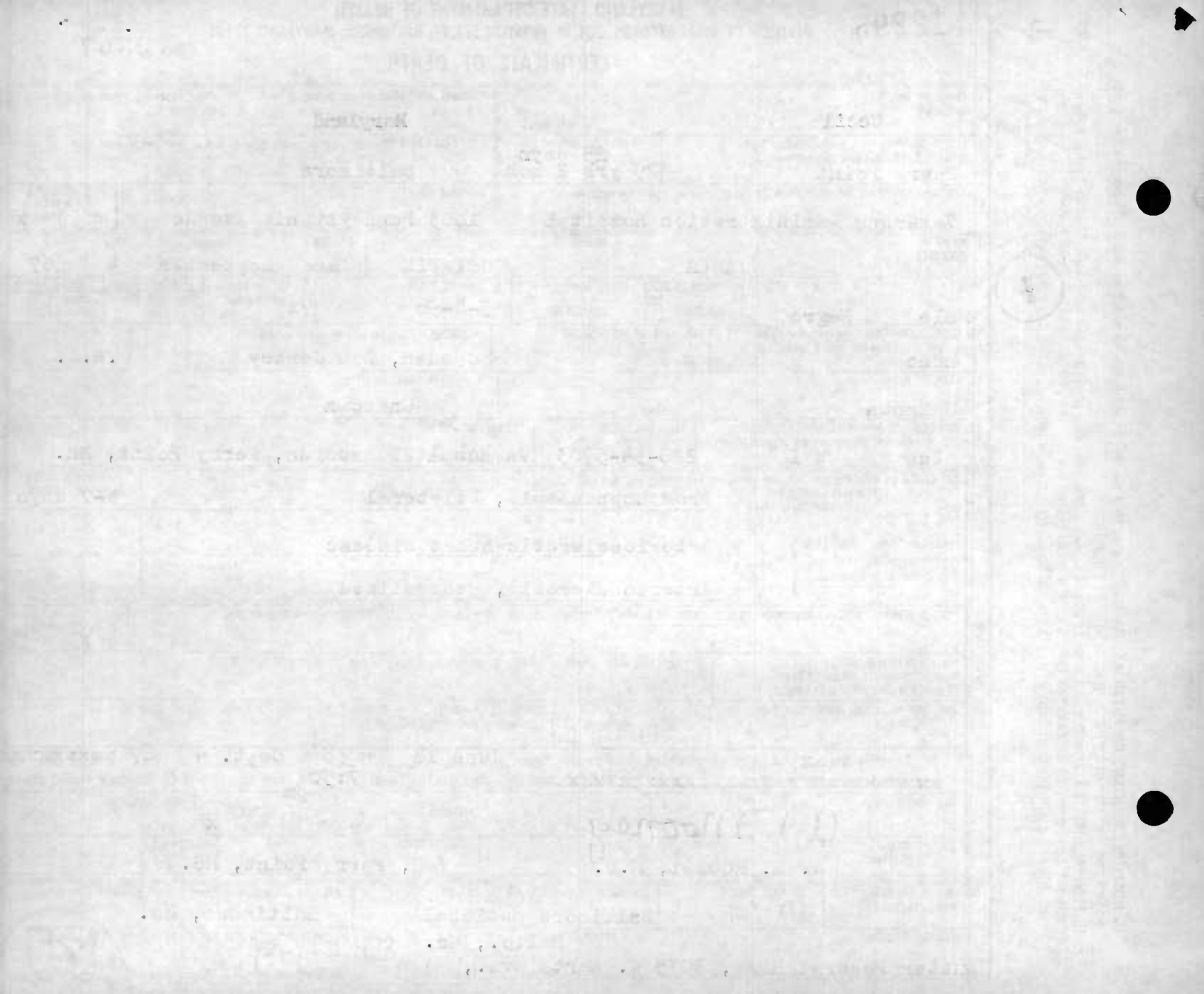
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12296		12307	
CERTIFICATE OF DEATH							
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 25 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1803 Pennsylvania Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JAMES GRIFFIN			4. DATE OF DEATH Month September Day 4 Year 1967				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 3-8-96		9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR: Months 4 Days 19 Hours 67 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Camden, New Jersey			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 220-54-5903		17. INFORMANT VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized INTERVAL BETWEEN ONSET AND DEATH 4-7 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (this hospital) attended the deceased from June 18 , 19 38 , to Sept. 4 , 19 67 , and that death occurred at 7:50 PM , from causes and on the date stated above.					
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.			
22d. ADDRESS VAH, Perry Point, Md.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) 9/11/67		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Baltimore National			
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		24. FUNERAL DIRECTOR Nutter Funeral Home, 3035 W. North Ave., Balto., Md.					
25a. REC'D BY REGISTRAR SEP 13 1967		25b. REGISTRAR'S SIGNATURE					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12297

CERTIFICATE OF DEATH

12308

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN TB 5 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS R.D. # 4	
3. NAME OF DECEASED (Type or print) First Sarah Middle A. Last Hagerman		4. DATE OF DEATH Month September Day 15 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 9, 1892
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 07 Days 07 Hours 07 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jake Puckett		14. MOTHER'S MAIDEN NAME Alafara Hicks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Mrs. Elizabeth Pearsall, Elkton, Md.	
17. INFORMANT Mrs. Elizabeth Pearsall, Elkton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Poisoning 260x DUE TO (b) Glomerulonephritis, Diabetic DUE TO (c) Diabetic Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/14 , 19 67 , to 9/15 , 19 67 , that (I) (we) lost sow the deceased alive on 9/15 , 19 67 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Rolando A. Najera		22b. DATE SIGNED 9/16/67	
22c. PHYSICIAN'S NAME (Type) Rolando A. Najera		22d. ADDRESS 105 E. Main St. Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/18/67	23c. NAME OF CEMETERY OR CREMATORY Puckett Cemetery	23d. LOCATION (City or Town) (County) (State) Bartley, West Virginia
24. FUNERAL DIRECTOR Alfred E. Hicks Hicks Home for Funerals, Elkton, Md.		25. REC'D BY REGISTRAR SEP 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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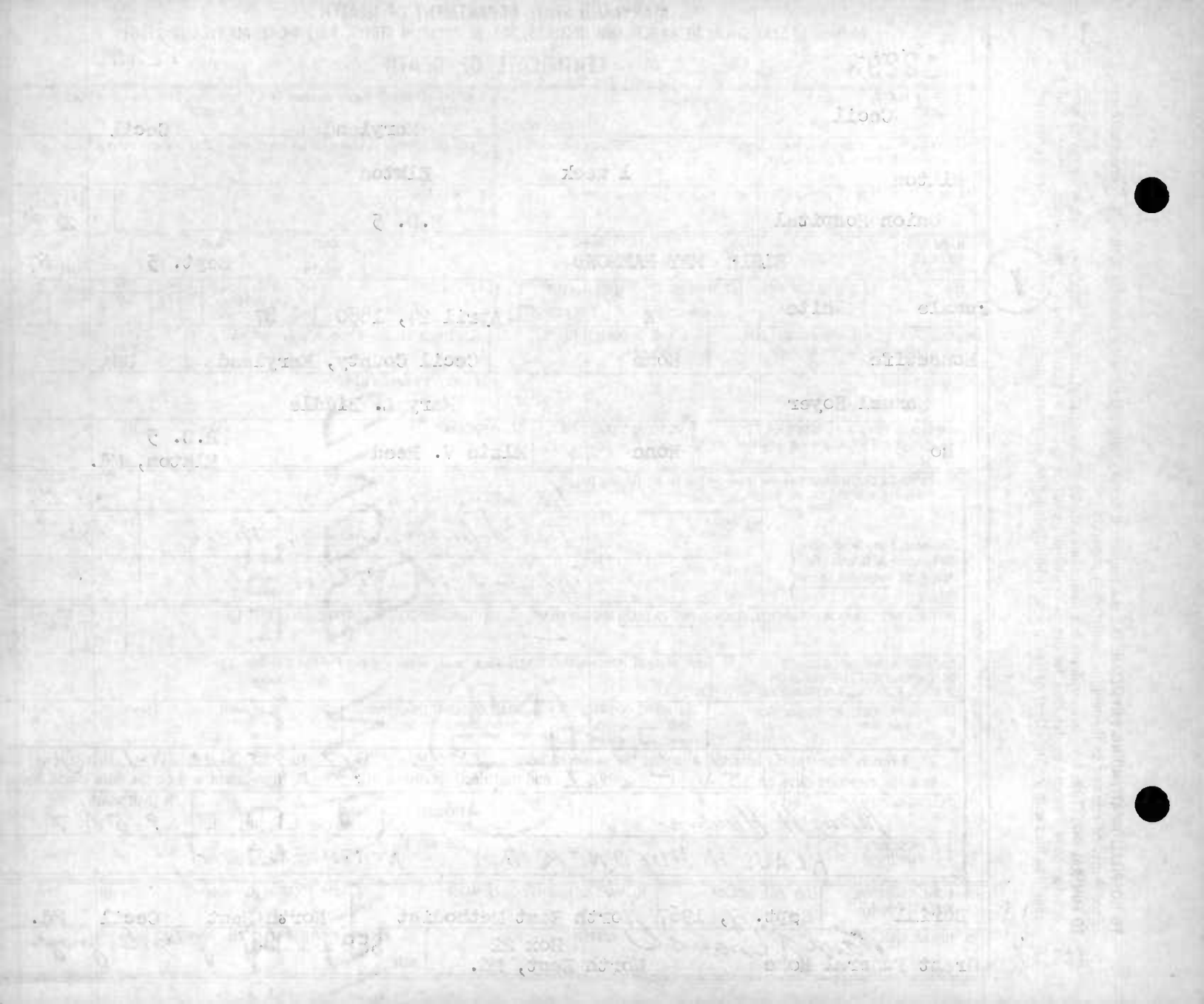
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12298

CERTIFICATE OF DEATH

12309

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 1 week	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. STREET ADDRESS R.D. 5	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELSIE MAY HAMMOND		4. DATE OF DEATH Month Sept. Day 5 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1880
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Cecil County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Boyer		14. MOTHER'S MAIDEN NAME Mary L. Biddle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Elsie V. Reed		Address R.D. 5 Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1810 Brouchopneumonia DUE TO (b) Iron deficiency anemia, severe DUE TO (c) Carcinoma of Bladder		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 1 yr? 1 yr?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) —		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 28 Aug., 1967 , to 5 Sept., 1967 , that (I) (we) last saw the deceased alive on 5 Sept. 1967 , and that death occurred at 3:40 A.M. from causes and on the date stated above.			
22a. SIGNATURE Klaus H. Huebner		22b. DATE SIGNED 9/5/67	
22c. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER M.D.		22d. ADDRESS NORTH EAST, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 9, 1967	23c. NAME OF CEMETERY OR CREMATORY North East Methodist	23d. LOCATION (City or Town) (County) (State) North East Cecil Md.
24. FUNERAL DIRECTOR Paul A. Crouch		25. REGISTERED BY REGISTRAR SEP 11 1967	
Grant Funeral Home		25b. REGISTRAR'S SIGNATURE Johnes Judge	



CERTIFICATE OF DEATH

12299

12310

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 72 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		e. STREET ADDRESS 223 Kennard Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Jerry C. HOLECK		4. DATE OF DEATH Month Day Year September 3, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-94
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY US govt. Ret.	
11. BIRTHPLACE (County & State, or foreign country) New York, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Holeck		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 220-20-78-00	
17. INFORMANT VA Hospital Records - Perry Point, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, Chronic and Acute 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Congestive Heart Failure DUE TO (c) Arteriosclerotic coronary heart disease Years			INTERVAL BETWEEN ONSET AND DEATH 5 days 5 months Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from 6-23-67 , 19 am to 9-3-67 , 19 pm , and that death occurred at 1:20 M, from causes and on the date stated above.			
22a. SIGNATURE IRINA REUS		22b. DATE SIGNED 9-3-67	
22c. PHYSICIAN'S NAME (Type) IRINA REUS		22d. ADDRESS VA Hospital - Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Church Cemetery	23d. LOCATION (City or Town) (County) (State) Joppa, Maryland
24. FUNERAL DIRECTOR MC COMAS FUNERAL HOME - Abingdon, Maryland		25a. REC'D BY REGISTRAR SEP 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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UNITED STATES OF AMERICA

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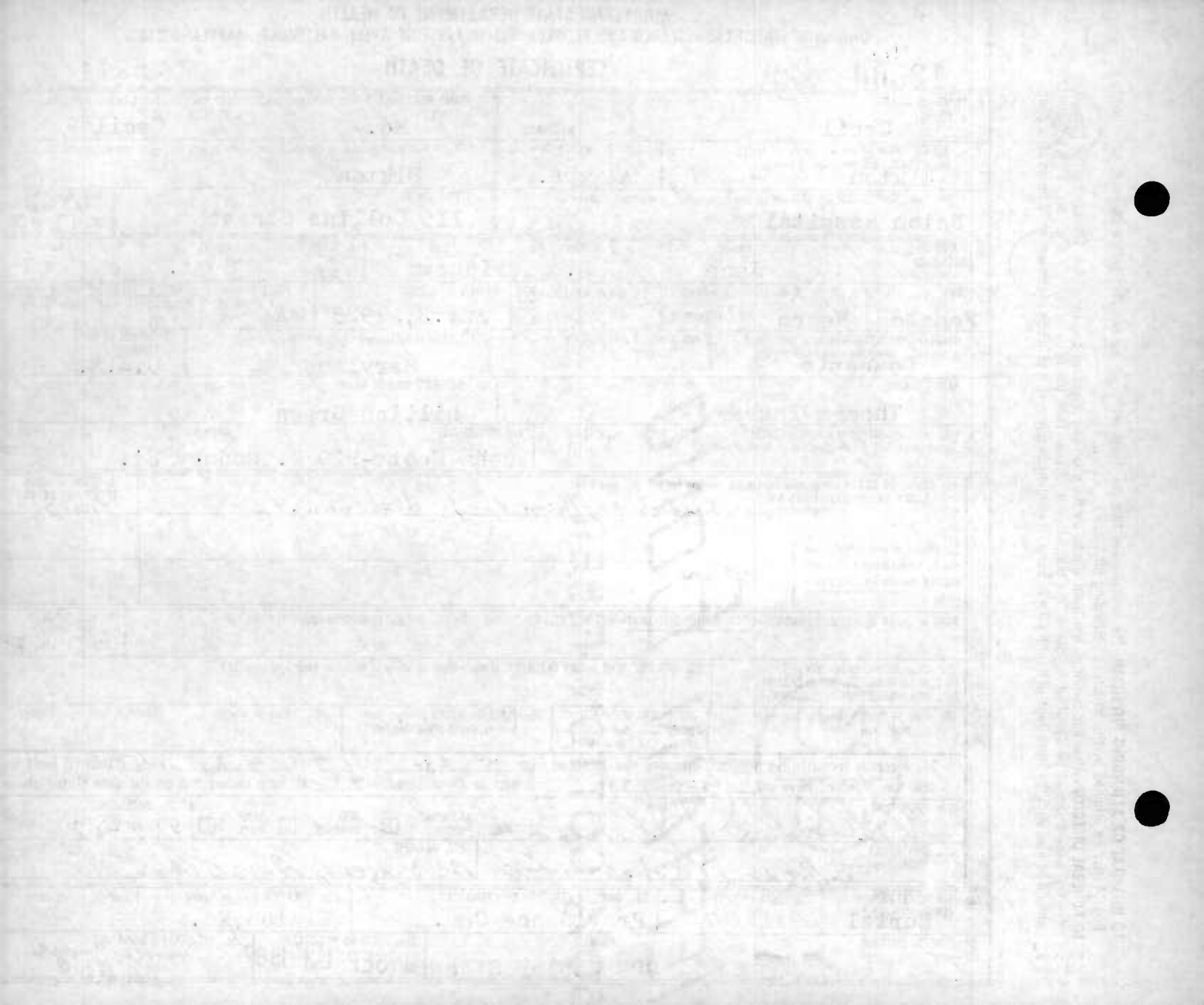
CERTIFICATE OF DEATH

12311

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 44 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 115 Collins Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jane E. Ingram				4. DATE OF DEATH Month Day Year Sept. 8 19 67			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 3, 1923	
9. AGE (In years) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Ingram				14. MOTHER'S MAIDEN NAME Lillian Green			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Reba Scott-229 N. Rodney St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 456 X IMMEDIATE CAUSE (a) Lupus erythematosus disseminata DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____							INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-23-1967, to 9-8-1967 that (I) (we) last saw the deceased alive on 9-7-1967, and that death occurred at 9:30 AM, from causes and on the date stated above.							
22a. SIGNATURE Tillman D. Johnson MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-9-67	
22c. PHYSICIAN'S NAME (Type) Tillman D. Johnson MD				22d. ADDRESS 123 Singler Ave, Elkton, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/12/67		23c. NAME OF CEMETERY OR CREMATORY Providence Cem.		23d. LOCATION (City or Town) (County) (State) Elkton, Md.	
24. FUNERAL DIRECTOR Calvin P. Bell				ADDRESS 909 Poplar Street		25a. REC'D BY REGISTRAR DATE SEP 13 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12301

CERTIFICATE OF DEATH

12312

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna b. COUNTY Chester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN lb 34 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA HOSPITAL PERRY POINT, MD.		d. STREET ADDRESS 213 W. 9th Street	
3. NAME OF DECEASED (Type or print) AUSTIN P JACKSON		4. DATE OF DEATH Month September Day 18 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-95
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 1 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (County & State, or foreign country) Port Deposit, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Wesley Jackson (Deceased)		14. MOTHER'S MAIDEN NAME Leona Woodrow (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 178-07-5614	
17. INFORMANT VA Hospital records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema with massive pleural effusion DUE TO (b) Acute & chronic myocardial infarctions DUE TO (c) Coronary thrombosis-Arteriosclerotic heart disease -- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH -----			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. Month, Day, Year 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug 15 , 1967, to Sept. 18 , 1967, and that death occurred at 9:30 PM , from causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 9-19-67	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.		22d. ADDRESS VA HOSPITAL,, PERRY POINT, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Sept. 22, 1967	23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery	23d. LOCATION (City or Town) (County) (State) Port Deposit, Md.
24. FUNERAL DIRECTOR Patterson Funeral Home, Perryville, Md.		25a. REC'D BY REGISTRAR DATE SEP 26 1967	
		25b. REGISTRAR'S SIGNATURE James Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 23b Film 2393 9/20/67 kk									
12302									
12313									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Ohio b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.			c. LENGTH OF STAY IN lb 4 days 1 yr 9 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cleveland				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS 9105 Birchdale Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last OLIN W. KELSEY					4. DATE OF DEATH Month Day Year September 8 1967				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-5-94		9. AGE (In years last birthday) yrs. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Unknown			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes give war or dates of service) WW I		16. SOCIAL SECURITY NO. 220-54-6140		17. INFORMANT Address VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO (b) Acute Myocardial Infarction DUE TO (c) Arteriosclerotic Heart Disease, Severe									INTERVAL BETWEEN ONSET AND DEATH 6-8 days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that XX this hospital attended the deceased from Dec. 8, 1965 , to Sept. 8, 1967 , that (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) saw the deceased alive on XXXXXX and that death occurred at 2:40 AM from causes and on the date stated above.									
22a. SIGNATURE A. L. Mooney					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.					22d. ADDRESS VA Hospital, Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 9-12-67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Carroll Funeral Home, 1529 E. North Ave.,					ADDRESS Balto., Md.		25a. REC'D BY REGISTRAR DATE SEP 26 1967		25b. REGISTRAR'S SIGNATURE J. Charles J...

2302

1941

4 days
1 to 2 mos

1941

1941

1941

1941

1941

1941

A. L. McCarry

A. L. McCarry, M.D.

CERTIFICATE OF DEATH

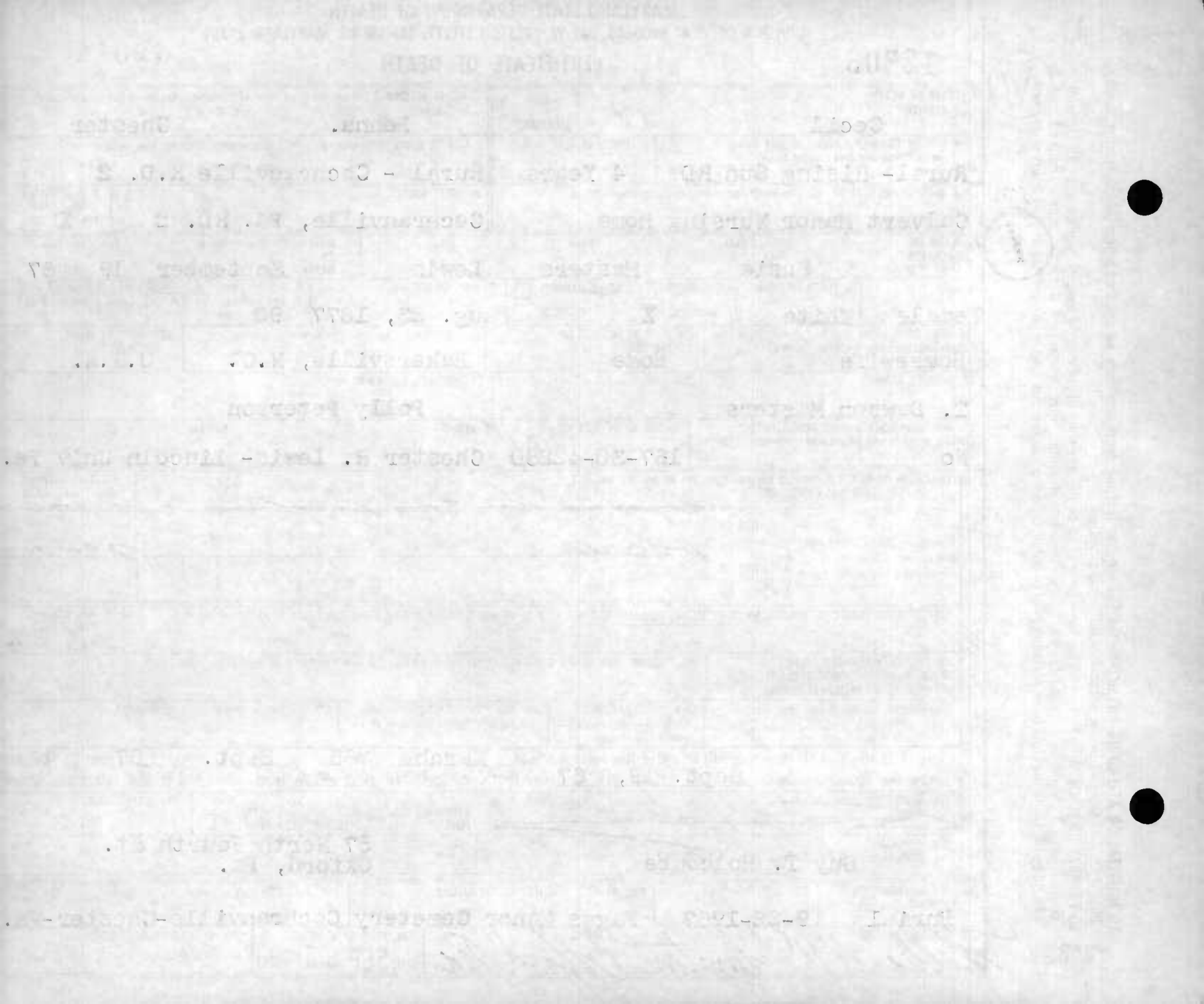
12303

12314

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY Chester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Rising Sun RD		c. LENGTH OF STAY IN lb 4 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Manor Nursing Home		e. STREET ADDRESS Cochranville, Pa. RD. 2	
3. NAME OF DECEASED (Type or print) First Susie Middle Masters Last Lewis		4. DATE OF DEATH Month September Day 19 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1877
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Bakersville, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME T. Dawson Masters		14. MOTHER'S MAIDEN NAME Polly Peterson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 167-30-4228D	
17. INFORMANT Chester R. Lewis - Lincoln Univ Pa.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ASCVD DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March , 19 65 , to Sept. , 19 67 that (I) did saw the deceased alive on Sept. 19, 1967 , and that death occurred at 90 M, from causes and on the date stated above.			
22a. SIGNATURE Guy T. Holcombe		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Guy T. Holcombe		22d. ADDRESS 57 North Fourth St. Oxford, Pa.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-28-1967	23c. NAME OF CEMETERY OR CREMATORY Faggs Manor Cemetery	23d. LOCATION (City or Town) (County) (State) Cochranville-Chester-Pa.
24. FUNERAL DIRECTOR William J. Holmstrom		25a. REC'D BY REGISTRAR SEP 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12304

CERTIFICATE OF DEATH

13771

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 220 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Solomons Island		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Francis Middle H. Last Lore		4. DATE OF DEATH Month September Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/95
9. AGE (In years lost birthday) yrs. 72		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter - Retired		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Calvert Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph C. Lore		14. MOTHER'S MAIDEN NAME Sarah Tucker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 577-12-37-50	
17. INFORMANT Hospital records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO (b) Congestive Heart Failure (c) Arteriosclerotic Heart Disease with Myocardial fibrosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Infarct, right			
19. INTERVAL BETWEEN ONSET AND DEATH 4-7 days Years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Feb. 21 , 19 67 , to Sept. 29 , 19 67 and that death occurred at 10:15 M, from causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 9-29-67	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL CROWNING, REMOVAL (Specify)		23b. DATE THEREOF Oct. 3, 1967	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Patterson Funeral Home, Perryville, Md.		25a. REC'D BY REGISTRAR DATE OCT 9 1967	
25b. REGISTRAR'S SIGNATURE James Judge			

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1512

12305

CERTIFICATE OF DEATH

12315

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 5 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elkton		d. STREET ADDRESS R.D. 5	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANDREA MAHONEY		4. DATE OF DEATH Month Sept. Day 22 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1944
9. AGE (In years last birthday) yrs. 23		IF UNDER 1 YEAR Months 23 Days 23 Hours 23 Min. 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	
11. BIRTHPLACE (County & State, or foreign country) Montgomery Co. Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Newton H. Mahoney Jr.		14. MOTHER'S MAIDEN NAME Irene K. Osenbach	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-42-9623	
17. INFORMANT Newton H. Mahoney Jr.		Address R.D. 5 Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4344 IMMEDIATE CAUSE (a) Rt. and Left Atrial and Ventricular Hypertrophy DUE TO (b) Pulmonary Hypertension DUE TO (c) Dilatation of main central pulmonary artery, cause unknown		INTERVAL BETWEEN ONSET AND DEATH 2 years 2 years (?) 5 years (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 2 Oct , 19 65 to 22 Sept , 19 67 , that (1) (we) last saw the deceased alive on 9/22 , 19 67 , and that death occurred at 5:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE Klaus H. Huebner		22b. DATE SIGNED 9/22/67	
22c. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER		22d. ADDRESS NORTH EAST, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-67	
23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City or Town) (County) (State) Elkton Cecil Md.	
24. FUNERAL DIRECTOR Grant Funeral Home		25a. REC'D BY REGISTRAR SEP 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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VR A15 (4)
20 M 1/66

1250

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

• *Journal of the American Medical Association* •

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• **1994** - **DOUGLAS**

51-24-24

FOR STATE
HEALTH DEPT.

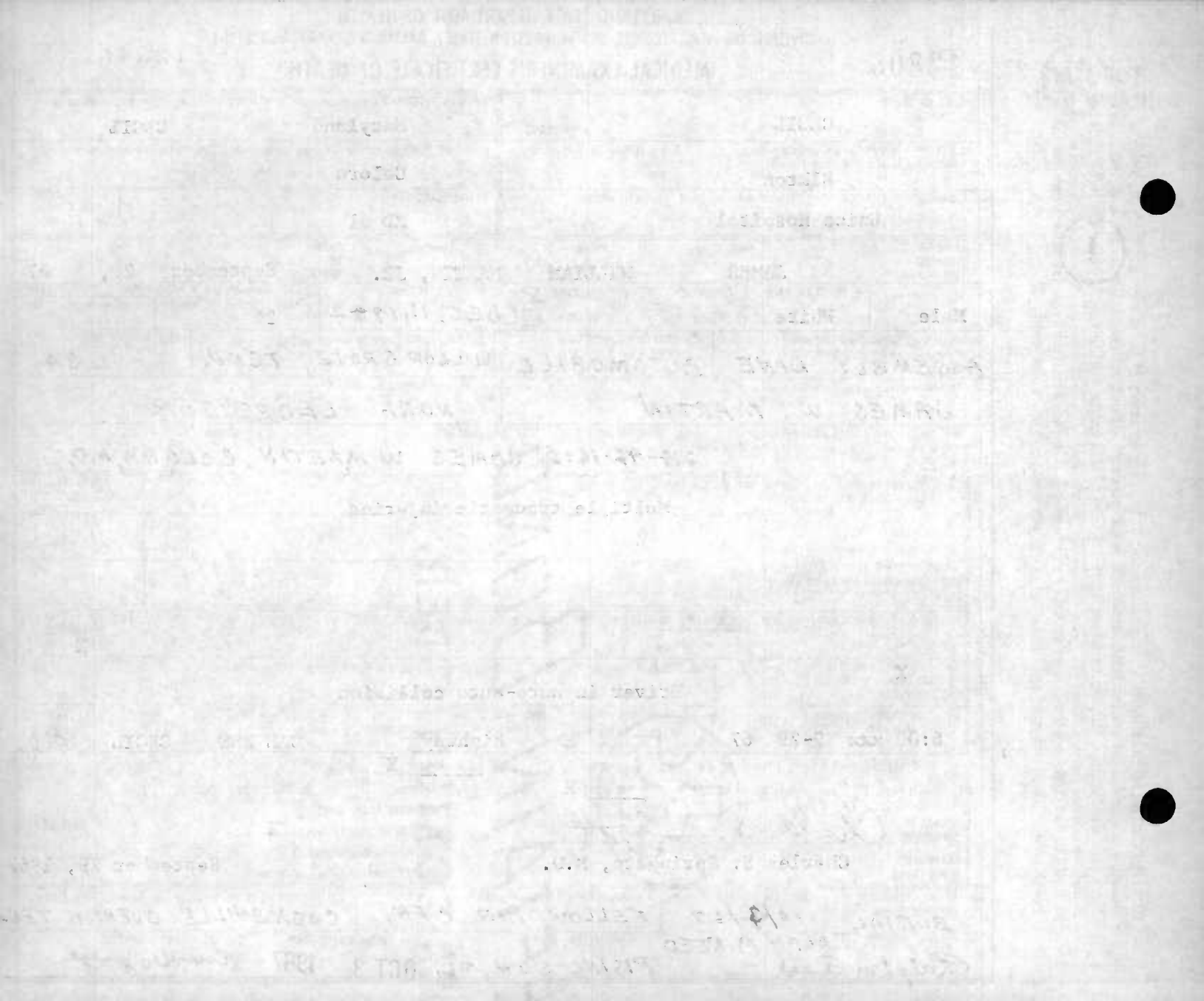
12306

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12316

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN fb 07.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS RD #1	
3. NAME OF DECEASED (Type or print) JAMES WILLIAM MARTIN, JR.		4. DATE OF DEATH Month September Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 11, 1942
9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months 11 Days 18 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSEMBLY LINE		10b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE	
11. BIRTHPLACE (State or foreign country) WILLOW GROVE, TENN.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES W. MARTIN		14. MOTHER'S MAIDEN NAME NORA LEDBETTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 214-42-1698	
17. INFORMANT JAMES W MARTIN, COLORA, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 816.4 IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver in auto-auto collision	
20c. TIME OF INJURY Month, Day, Year 6:00 a.m. 9-29 1967		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		20f. (City or town) (County) (State) CALVERT CECIL MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		22. DATE SIGNED September 29, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/4/67	23c. NAME OF CEMETERY OR CREMATORY FELLOWSHIP CEM.	23d. LOCATION (City or Town) (County) (State) COCKEVILLE OVERTON TENN.
24. FUNERAL DIRECTOR RALPH M. REED		25a. REC'D BY REGISTRAR OCT 3 1967	
ADDRESS Rising Sun, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12307

CERTIFICATE OF DEATH

12317

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON			c. LENGTH OF STAY IN 1b 2 WEEKS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORTH EAST			07-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL				d. STREET ADDRESS 122 S MAIN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SMITH Cooper Mc Ginnes			First	Middle	Last	4. DATE OF DEATH Month 9 Day 16 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-17-93		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 1 Days 19	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES			10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD		11. BIRTHPLACE (County & State, or foreign country) M.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN MCGINNES				14. MOTHER'S MAIDEN NAME MARY LOU NICKERSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. 200-09-8435		17. INFORMANT ELSIE M. WELLER Address NORTH EAST MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 4342 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Edema DUE TO (c) Diarrhea with Rectal Bleeding							INTERVAL BETWEEN ONSET AND DEATH 13-Days 13-Days 1-Day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/3/67 , 19 67 , to 9/16/67 , 19 67 , that (I) (we) saw the deceased alive on 9/16/67 , and that death occurred on 5:45 A.M. from causes on and on the date stated above.							
22a. SIGNATURE James L. Johnson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/18/67	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.				22d. ADDRESS 245 E. High, St. Elkton Cecil Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-19-67		23c. NAME OF CEMETERY OR CREMATORY NORTH EAST METH.		23d. LOCATION (City or Town) (County) (State) NORTH EAST CECIL MD	
24. FUNERAL DIRECTOR GRANT FUNERAL HOME				25a. REC'D BY REGISTRAR SEP 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12308

CERTIFICATE OF DEATH

12318

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN 1b 55 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 222 East Thomas Ave.				d. STREET ADDRESS 222 East Thomas Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) REED CULBERSTON McKinney First Middle Last				4. DATE OF DEATH Sept. 26 19 67 Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1892		9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Cecil Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stephen W. McKinney				14. MOTHER'S MAIDEN NAME Mary Mahoney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Edgar R. McKinney		Address North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) CARCINOMA OF LEFT LUNG DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 5 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive Cardiovascular Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, allice bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 5/31 , 19 67 , to 9/26 , 19 67 , that (I) (we) last saw the deceased alive on 9/14 , 19 67 , and that death occurred at 3A M, from causes and on the date stated above.							
22a. SIGNATURE Klaus H. Huebner				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/26/67	
22c. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER				22d. ADDRESS NORTH EAST, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-29-67	23c. NAME OF CEMETERY OR CREMATORY North East Methodist		23d. LOCATION (City or Town) (County) (State) North East Cecil Md.			
24. FUNERAL DIRECTOR Grant Funeral Home		ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR SEP 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

12309

12319

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 27 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Herbert Clinton McVey		4. DATE OF DEATH Month Day Year September 7 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-89
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (County & State, or foreign country) Edgewood, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John J. McVey (D)		14. MOTHER'S MAIDEN NAME Martha Hopper Hoopes (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 217-16-1947	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO (b) Congestive heart failure DUE TO (c) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 5-6 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that XXXXXX attended the deceased from August 11, 19 67 , to Sept. 7, 19 67 , and that death occurred at 7:50 PM , from causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 9-8-67	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.		22d. ADDRESS VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-Sep.-67	23c. NAME OF CEMETERY OR CREMATORY St Paul Lutheran Cemetery, Aberdeen, Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR TARRING FUNERAL HOME, Aberdeen, Md.		25a. REC'D BY REGISTRAR DATE SEP 11 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12310

CERTIFICATE OF DEATH

12320

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY CECIL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE DEL. b. COUNTY NEW CASTLE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ELKTON | | c. LENGTH OF STAY IN 1b
153 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
UNION HOSPITAL | | d. STREET ADDRESS
BEAR | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 46-3 | |
| 3. NAME OF DECEASED (Type or print)
First HARRY Middle B. Last MOORE | | 4. DATE OF DEATH
Month SEPT. Day 18 Year 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MARCH 28, 1895 |
| 9. AGE (In years last birthday)
72 yrs. | | 10. IF UNDER 1 YEAR
Months 1 Days 18 Hours 19 Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FARMER | | 12. 10b. KIND OF BUSINESS OR INDUSTRY
FARMING | |
| 13. FATHER'S NAME
GEORGE MOORE | | 14. MOTHER'S MAIDEN NAME
MARY C. WHITE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO.
WW # 0 222-22-0358A | |
| 17. INFORMANT
FRANCIS H. MOORE - BEAR, DEL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abdominal abscess
DUE TO
(b) Ruptured diverticulum of sigmoid Colon
DUE TO
(c) Diverticulitis of Colon | | INTERVAL BETWEEN ONSET AND DEATH
2 months
2 month
years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Generalized Arteriosclerosis | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 9-17 , 1967, to 9-18 , 1967, that (I) (we) lost saw the deceased alive on 9-17 , 1967, and that death occurred at 11:35 AM , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
Williford Eppes | | 22b. DATE SIGNED
9-21-67 | |
| 22c. PHYSICIAN'S NAME (Type)
WILLIFORD EPPES | | 22d. ADDRESS
327 E. MAIN ST. NEWARK, DEL. | |
| 23a. BURIAL, CREMATION, REMOVED (Specify)
BURIAL | 23b. DATE THEREOF
9/21/67 | 23c. NAME OF CEMETERY OR CREMATORY
PRESBYTERIAN CEM | 23d. LOCATION (City or Town) (County) (State)
CHRISTIANNA DEL. |
| 24. FUNERAL DIRECTOR
PIPPIN FUNERAL HOME | | 25a. REC'D BY REGISTRAR
SEP 25 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

STATEMENT OF WORK

12345



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| Project Overview | |
| Project Name: [Faint text] | |
| Project Manager: [Faint text] | |
| Project Start Date: [Faint text] | |
| Project End Date: [Faint text] | |
| Project Budget: [Faint text] | |
| Project Scope: [Faint text] | |
| Project Risks: [Faint text] | |
| Project Deliverables: [Faint text] | |
| Project Milestones: [Faint text] | |
| Project Status: [Faint text] | |
| Project Comments: [Faint text] | |
| Project Sign-off: [Faint text] | |
| Project Approval: [Faint text] | |
| Project Review: [Faint text] | |
| Project Feedback: [Faint text] | |
| Project Conclusion: [Faint text] | |

This document is a statement of work for the project. It is intended to provide a clear and concise overview of the project's goals, objectives, and deliverables. The project manager is responsible for ensuring that the project is completed on time, within budget, and to the satisfaction of the client.

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VR A15 (4)
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

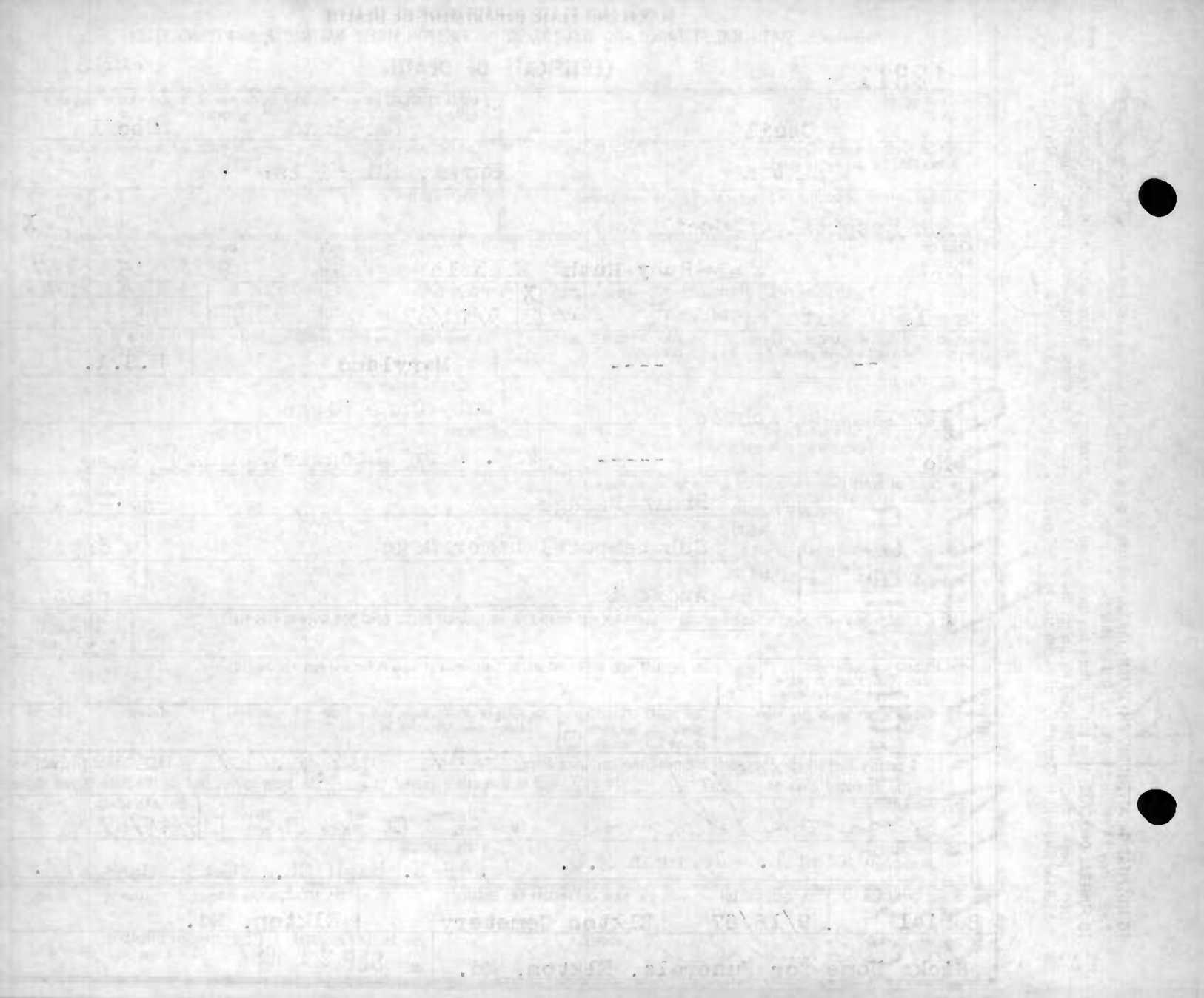
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12311

CERTIFICATE OF DEATH

12321

| | | | |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> | | c. LENGTH OF STAY IN 1b | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Elk Mills, Md.</u> | | d. STREET ADDRESS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital Of Cecil County</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Ruby Ruth Nichols</u> | | 4. DATE OF DEATH Month Day Year <u>9 15 19 67</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/10/67</u> |
| 9. AGE (In years last birthday) yrs. <u>5</u> | | IF UNDER 1 YEAR Months Days Hours Min. <u>5</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Larry Eugene Nichols</u> | | 14. MOTHER'S MAIDEN NAME <u>Ruby Jane Biggs</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-----</u> | |
| 17. INFORMANT Address <u>Mrs. Larry Nichols (Mother) Same</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Brain Damage</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sub temporal hemorrhage</u>
DUE TO (c) <u>Anoxemia</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 Days</u>
<u>4 days</u>
<u>4 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/10/</u> , 19 <u>67</u> , to <u>9/15/</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>9/15/</u> , 19 <u>67</u> , and that death occurred at <u>2 A</u> :M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>James L. Johnson</u> | | 22b. DATE SIGNED <u>9/15/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>James L. Johnson M.D.</u> | | 22d. ADDRESS <u>245 E. High St., Elkton Cecil Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>9/16/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Elkton, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Hicks & Licks</u> | | 25a. REC'D BY REGISTRAR <u>SEP 21 1967</u> | |
| ADDRESS <u>Hicks Home for Funerals, Elkton, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



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VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|---|---|--|--|--|---|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 12312 | | | | | CERTIFICATE OF DEATH | | | 12322 | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Elkton</u> | | | c. LENGTH OF STAY IN lb
<u>D.O.A.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Elkton</u> | | | 071 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Union Hospital</u> | | | | | d. STREET ADDRESS
<u>186 Hollingsworth Manor</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print) <u>Clarence</u> First <u>Edker</u> Middle <u>Odum</u> Last | | | | | 4. DATE OF DEATH
Month <u>Sept.</u> Day <u>27</u> Year <u>67</u> | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>July 16, 1907</u> | | 9. AGE (In years last birthday) yrs. <u>60</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)
<u>Aid</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>V.A. Hospital</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Bristol, Virginia</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 13. FATHER'S NAME
<u>David Odum</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Daisy</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> | | | 16. SOCIAL SECURITY NO.
<u>WA #2 225-03-3198</u> | | 17. INFORMANT
<u>Mrs. Ruth J. Odum, Elkton, Maryland.</u> Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>
DUE TO <u>4201</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Coronary Heart Disease</u>
DUE TO <u>AND</u>
(c) <u>AND</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>?</u>
<u>?</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>None</u> | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>None</u> | | | | | | |
| 20c. TIME OF INJURY
Hour a.m. <u>19</u> Month, Day, Year
p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/10/67</u> , 19 <u>67</u> , to <u>9/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>12:57</u> M, from causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
<u>Peter Stankis</u> | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>9/27/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>PETER STANKIS M.D.</u> | | | | | 22d. ADDRESS
<u>ELKTON MD</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>9-30-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Elkton Cemetery</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>Elkton Cecil Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>PIPPIN FUNERAL HOME</u> | | | | | ADDRESS
<u>Douglas B. De</u> | | 25a. REC'D BY REGISTRAR
DATE <u>SEP 25 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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1957

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

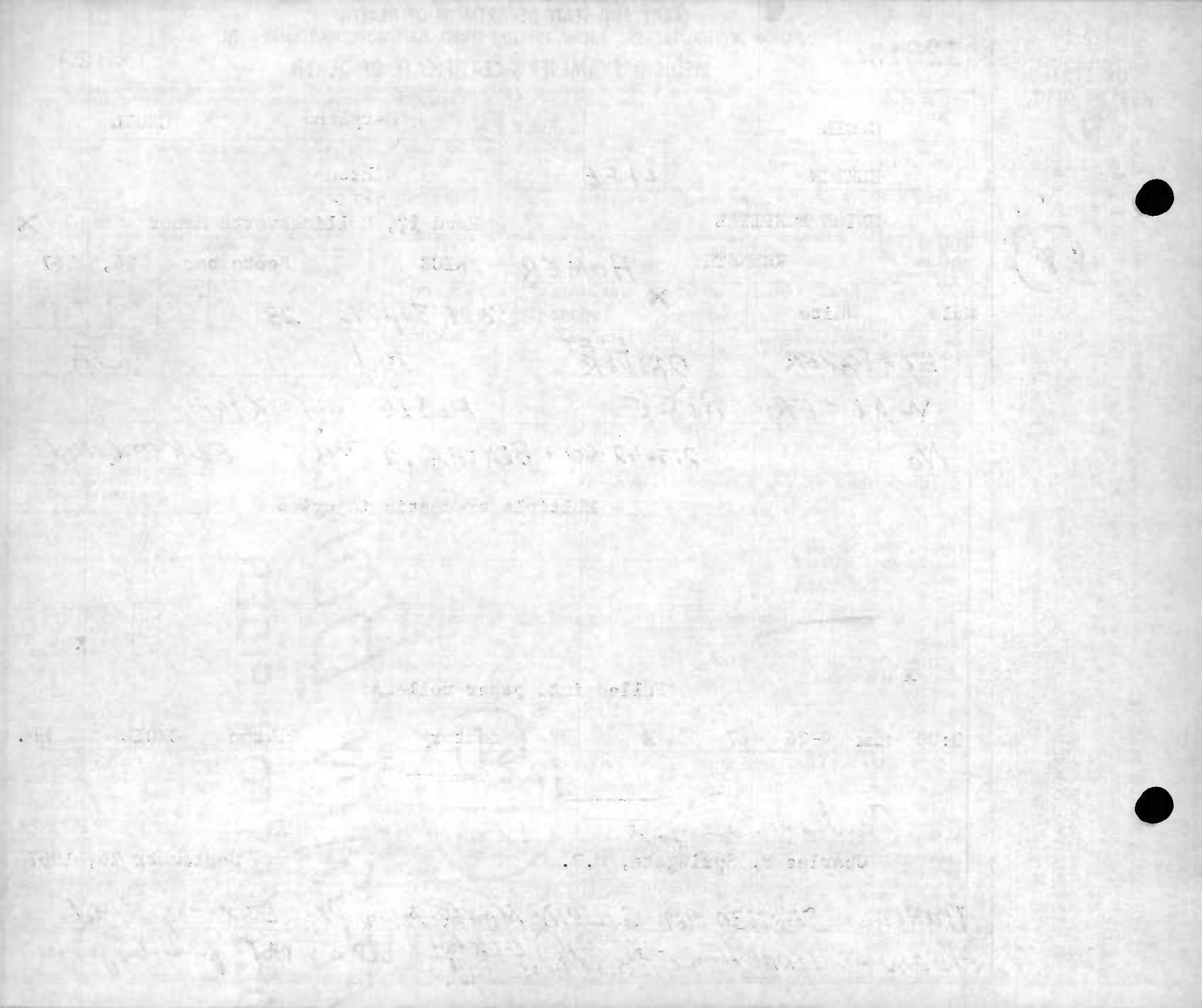
12313

12323

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|--|---|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY CECIL MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY CECIL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ELKTON | | | c. LENGTH OF STAY IN 1b
LIFE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Elkton | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
UNION HOSPITAL | | | | d. STREET ADDRESS
Road 13, Hollingsworth Manor | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First KENNETH Middle HOMER Last RICE | | | | 4. DATE OF DEATH
Month September Day 26 Year 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
SEPT. 30, 1943 | | 9. AGE (In years last birthday) yrs. 23 | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)
ELK PAPER | | 10b. KIND OF BUSINESS OR INDUSTRY
DRIVER | | 11. BIRTHPLACE (State or foreign country)
Md | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
WALTER RICE | | | | 14. MOTHER'S MAIDEN NAME
ELSIE HICKMAN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-42-4063 | | 17. INFORMANT
BERTHA M. RICE Address ELKTON, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple traumatic injuries
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 9123 | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Pulled into paper rollers | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 3:00 xxx 9-26 1967 | | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
factory | | 20f. (City or town) (County) (State)
Elkton CECIL MD. | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
<i>Charles S. Springate</i> | | M.D.
Charles S. Springate, M.D. | | 22. DATE SIGNED
September 26, 1967 | | | |
| EXAMINER'S NAME (Type) | | Address (Street, city, town, or county) | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
SEPT. 30, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
GILPIN MANOR MEM. PK | | 23d. LOCATION (City or Town) (County) (State)
ELKTON, MD. | | | |
| 24. FUNERAL DIRECTOR
PIPPIN FUNERAL HOME | | ADDRESS
Elkton Md | | 25a. RECD BY REGISTRAR
SEP 28 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |



CERTIFICATE OF DEATH

12314

12324

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|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Cecil
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Elkton | |
| c. LENGTH OF STAY IN lb
1 day | | d. STREET ADDRESS
R.D. # 4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Union Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Alice A. Scarborough | | 4. DATE OF DEATH
Month Sept. Day 22 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 18, 1904 |
| 9. AGE (In years lost birthday)
63 yrs. | | 10. IF UNDER 1 YEAR
Months 22 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
-- | |
| 11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Howard Spencer Gerber | | 14. MOTHER'S MAIDEN NAME
Mattie Throne | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
T. Alfred Scarborough, Elkton, Md. | | Address R.D. 4 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO
(b) Coronary artery thrombosis
DUE TO
(c) Arteriosclerotic Heart Disease
INTERVAL BETWEEN ONSET AND DEATH
18h.
18h.
Years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (H) (this hospital) attended the deceased from 9-21- , 19 67 , to 9-22- , 19 67 , that (I) (we) last saw the deceased alive on 9-22- , 19 67 , and that death occurred at 12:45 M, from causes and on the date stated above | | | |
| 22a. SIGNATURE
Tillman D. Johnson M.D. | | 22b. DATE SIGNED
9-25-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Tillman D. Johnson M.D. | | 22d. ADDRESS
123 Singlerly Ave, Elkton, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
9/25/67 | 23c. NAME OF CEMETERY OR CREMATORY
Sharps Cemetery | 23d. LOCATION (City or Town) Elkton, P.O. (State) Md. |
| 24. FUNERAL DIRECTOR
Ralph E. Hicks ADDRESS
Hicks Home for Funerals, Elkton, Md. | | 25a. REC'D BY REGISTRAR
SEP 28 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12315

CERTIFICATE OF DEATH

12325

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Cecil
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bay View | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural, R. D. 4, Elkton, Md. | |
| c. LENGTH OF STAY IN 1b
1 month | | d. STREET ADDRESS
071 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Susan J. Schaible | | 4. DATE OF DEATH
Month Sept. Day 14 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 17, 1891 |
| 9. AGE (In years last birthday)
75 yrs. | | 10. IF UNDER 1 YEAR
Months 14 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Cecil County, Maryland U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Samuel Reynolds Guiberson | | 14. MOTHER'S MAIDEN NAME
Susan Jane Hammond | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Raymond Guiberson, Bay View, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO
(b) Arteriosclerotic cardiovascular disease
DUE TO
(c) Arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
County coroner, Dr. John Byers, was called & notified at death | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from X , 19__, to X , 19__, that (I) (we) last saw the deceased alive on X , 19__, and that death occurred at 11:30 AM , from causes and on the date stated above. | |
| 22a. SIGNATURE
Jay S. Barnhart, Jr. | | 22b. DATE SIGNED
9-16-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Jay S. Barnhart, Jr. M.D. | | 22d. ADDRESS
3 Mauldin Avenue, North East, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Sept. 18, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Cherry Hill Meth. Cem. | | 23d. LOCATION (City or Town) Elkton, Md. (State) Cecil | |
| 24. FUNERAL DIRECTOR
Hicks Home for Funerals, Elkton, Md. | | 25a. RECEIVED BY REGISTRAR
SEP 21 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1815

General R. D. A. Linton, Md.
1 month
General R. D. A. Linton, Md.

Nov. 1, 1891
Housewife
General R. D. A. Linton, Md.
General R. D. A. Linton, Md.
General R. D. A. Linton, Md.

Nov. 1, 1891
Housewife
General R. D. A. Linton, Md.
General R. D. A. Linton, Md.
General R. D. A. Linton, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12316
CERTIFICATE OF DEATH
12326

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North East
c. LENGTH OF STAY IN 1b 45 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 115 Wallace Ave. | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Cecil
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North East
d. STREET ADDRESS 115 Wallace Ave.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Sarah Middle Lucille Last Shepherd | | | | 4. DATE OF DEATH
Month Sept. Day 15 Year 1967 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Sept. 19, 1885 | |
| 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR
Months 81 Days 15 Hours 19 Min. 67 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Jackson Co. Ky. | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Richard Hayes | | 14. MOTHER'S MAIDEN NAME Sarah Engle | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. 102 Jethro St. North East, Md. | | 17. INFORMANT James E. Shepherd | | Address 102 Jethro St. North East, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic congestive heart failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile and arteriosclerotic cardiovascular disease
DUE TO (c) Diabetes mellitus, controlled hypertension | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus, controlled hypertension | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Hour 19 a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from 8-22 , 19 63 to 9-15 , 19 67 , that (1) (we) last saw the deceased alive on 9-15 , 19 67 , and that death occurred at 3:30 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Jay S. Barnhart Jr. M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 9-15-67 | |
| 22c. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr. | | | | 22d. ADDRESS 4 Mauldin Ave. North East, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 9-18-67 | | 23c. NAME OF CEMETERY OR CREMATORY North East Methodist | | 23d. LOCATION (City, town or county) (State) North East Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert Grant ADDRESS Box 22 North East, Md. | | | | 25e. REC'D BY REGISTRAR SEP 19 1967 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

12216

Local

Local

Local

115 W. 1st St.
115 W. 1st St.

115 W. 1st St.

115 W. 1st St.
115 W. 1st St.



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115 W. 1st St.

115

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12317

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12327

| | | | |
|--|-------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md.
b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Hacks Point | | c. LENGTH OF STAY IN 1b
DOA | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - R.D. 3, Elkton | | d. STREET ADDRESS
Oldfield Point Road | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Michael John Sherlock, Jr. | | 4. DATE OF DEATH
Month 9 Day 9 Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 22, 1948 |
| 9. AGE (In years last birthday)
18 yrs. | | IF UNDER 1 YEAR
Months 9 Days 9 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | 10b. KIND OF BUSINESS OR INDUSTRY
School | |
| 11. BIRTHPLACE (State or foreign country)
Delaware | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Michael John Sherlock, Sr. | | 14. MOTHER'S MAIDEN NAME
Elizabeth Marie deHan | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Michael J. Sherlock, Sr. Elkton, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Crushing of Chest
DUE TO
(b) Automobile Accident
DUE TO
(c) 8164
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH
Instant. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Pressed against steering wheel in 2-car collision | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 1:05 - 9-9 1967 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Rte 213 Hwy. | | 20f. (City or town) (County) (State)
Hr. Bohemian R. Bridge, Cecil, Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
John M. Byers, M.D. | | 22. DATE SIGNED
9-9-67
Elkton, Md. | |
| EXAMINER'S NAME (Type)
John M. Byers, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
9/12/67 | 23c. NAME OF CEMETERY OR CREMATORY
Immaculate Conception | 23d. LOCATION (City or Town) (County) (State)
Cherry Hill, Md. |
| 24. FUNERAL DIRECTOR
Ralph E. Hicks | | 25a. REC'D BY REGISTRAR
SEP 14 1967 | |
| Hicks Home for Funerals, Elkton, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12318

Item #23c Film #G392 9/20/67 ph

CERTIFICATE OF DEATH

12328

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Elkton</u> | | c. LENGTH OF STAY IN lb
<u>16 Hrs.</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Elkton</u> <u>07.1</u> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Union Hospital</u> | | d. STREET ADDRESS
<u>6 Curtis Lane</u> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Paul Theodore Simmons</u> | | 4. DATE OF DEATH Month Day Year
<u>Sept. 8, 1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>April 26, 1911</u> |
| 9. AGE (In years last birthday) yrs.
<u>56</u> | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Machinist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Self-Employed</u> | 11. BIRTHPLACE (County & State, or foreign country)
<u>Elkton, Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>John Simmons</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Mary Dick</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | |
| 16. SOCIAL SECURITY NO.
<u>216-01-4589</u> | | 17. INFORMANT Address
<u>Mrs. Vivian Simmons, Elkton, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 Coronary insufficiency</u>
DUE TO (b) <u>Calcific Aortic stenosis</u>
DUE TO (c) <u>2 yrs</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>24 hr</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-6</u> , 19 <u>66</u> , to <u>9-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-7</u> 19 <u>67</u> , and that death occurred at <u>12:35</u> AM, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Williford Egges</u> | | 22b. DATE SIGNED
<u>9-9-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Williford Egges, M.D.</u> | | 22d. ADDRESS
<u>Newark, Delaware</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>9-12-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gilpin Manor Mem. Park</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Elkton, Cecil, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>PIPPIN FUNERAL HOME</u> | | 25a. REC'D BY REGISTRAR
<u>SEP 13 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

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CERTIFICATE OF DEATH

12329

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| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Childs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Childs | |
| c. LENGTH OF STAY IN 1b
40 yrs. | | d. STREET ADDRESS
07-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Cora Middle A. Last Simpson | | 4. DATE OF DEATH
Month Sept. Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 25, 1874 |
| 9. AGE (In years last birthday)
92 yrs. | | 10. IF UNDER 1 YEAR
Months 23 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
-- | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles W. Howeth | | 14. MOTHER'S MAIDEN NAME
Annie Ford | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Gertrude G. Walker, Childs, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
DUE TO (b) 4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 4200
DUE TO (c) 4200 | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan., 1960 , to Sept. 23, 1967 , that (I) (we) lost the deceased alive on Sept. 23, 1967 , and that death occurred at 3 A.M. , from causes on the date stated above. | | | |
| 22a. SIGNATURE
Tillman D. Johnson M.D. | | 22b. DATE SIGNED
4-23-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Tillman D. Johnson M.D. | | 22d. ADDRESS
123 Sinslerg Ave., Elkton, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
9/27/67 | 23c. NAME OF CEMETERY OR CREMATORY
Elkton Cemetery | 23d. LOCATION (City or Town) (County) (State)
Elkton, Md. |
| 24. FUNERAL DIRECTOR
Ralph E. Hicks | | 25a. REC'D BY REGISTRAR
SEP 28 1967 | |
| ADDRESS
Hicks Home for Funerals, Elkton, Md. | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| NAME
[Faint text] | | ADDRESS
[Faint text] | |
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[Faint text] | | STATE
[Faint text] | |
| ZIP
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| PHONE
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| OCCUPATION
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| EMPLOYER
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| SIGNATURE
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| COMMENTS
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UNITED STATES DEPARTMENT OF AGRICULTURE
 BUREAU OF PLANT INDUSTRY
 OFFICE OF THE CHIEF, BUREAU OF PLANT INDUSTRY
 WASHINGTON, D. C. 20250-1500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12320

CERTIFICATE OF DEATH

12330

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/>
a. STATE Delaware b. COUNTY N.C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Elkton | | c. LENGTH OF STAY IN 1b
1 Day | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Union Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural-Newark 46.3 | |
| 3. NAME OF DECEASED
(Type or print) Michael P. Toomey | | d. STREET ADDRESS
Sunset Lake Road | |
| First Middle Last | | 4. DATE OF DEATH
Month Sept. Day 26 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 25, 1912 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chemical mixer | | 10b. KIND OF BUSINESS OR INDUSTRY
Chemical | 9. AGE (In years last birthday) yrs. 55 |
| 13. FATHER'S NAME
Hugh J. Toomey | | 14. MOTHER'S MAIDEN NAME
Catherine C. Kelleher | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes | | 16. SOCIAL SECURITY NO.
221-09-1645 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Respiratory Failure
DUE TO (b) Pneumonia
DUE TO (c) 1 week | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes mellitus, severe chronic HAND. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 20g. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 9/25 , 19 67 , to 9/26 , 19 67 , that (I) (we) last saw the deceased alive on 9/25 , 19 67 , and that death occurred at 1:00 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Peter Stavrakis MD | | 22b. DATE SIGNED
9/28/67 | |
| 22c. PHYSICIAN'S NAME (Type)
PETER STAVRAKIS MD | | 22d. ADDRESS
ELKTON MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Sept. 29, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. John's Cem. | | 23d. LOCATION (City or Town) (County) (State)
Newark, Delaware | |
| 24. FUNERAL DIRECTOR
R.T. Jones | | 25a. REC'D BY REGISTRAR
SEP 29 1967 | |
| ADDRESS
Newark, Delaware | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12321

CERTIFICATE OF DEATH

12331

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Elkton</u> | | c. LENGTH OF STAY IN lb
<u>Life</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Union Hospital</u> | | d. STREET ADDRESS
<u>179 Hollingsworth Manor</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>BLANCHE MAE TWEED</u> | | 4. DATE OF DEATH <u>September 14, 1967</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 23, 1904</u> | |
| 9. AGE (In years last birthday) <u>63</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>15</u> Days <u>10</u> Hours <u>15</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>at home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>North East, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>James Mc Dowell</u> | | 14. MOTHER'S MAIDEN NAME
<u>Emma Logal</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>218-22-8946</u> | |
| 17. INFORMANT
<u>Lester E. O'Brien Elkton, Md.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
DUE TO (b) <u>Cerebral Occlusion</u>
DUE TO (c) <u>HABIT</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>15 min.</u>
<u>10 min.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Marked Obesity</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>9/14, 1967</u> , that (I) (we) last saw the deceased alive on <u>1967</u> , and that death occurred at <u>12:17</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Peter Stavrakis</u> | | 22b. DATE SIGNED
<u>9/15/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Peter Stavrakis</u> | | 22d. ADDRESS
<u>W. Main St., Elkton, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Sept. 17, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Newark Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Newark, Delaware</u> | |
| 24. FUNERAL DIRECTOR
<u>PIPPIN FUNERAL HOME</u> | | 25a. REC'D BY REGISTRAR
DATE <u>SEP 20 1967</u> | |
| ADDRESS
<u>Elkton, Md.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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CONFIDENTIAL

CERTIFICATE OF DEATH

12322

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE DISTRICT OF COLUMBIA | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point | | c. LENGTH OF STAY IN 1b
5 Yrs 7-Mo 3 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VA Hospital | | | d. STREET ADDRESS
3704 30th Pl N.E. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
Claude W. UNDERWOOD | | | 4. DATE OF DEATH
Month September Day 24 Year 1967 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-28-00 | 9. AGE (In years lost birthday) yrs.
67 | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Printer | | 10b. KIND OF BUSINESS OR INDUSTRY
Printing | | 11. BIRTHPLACE (County & State, or foreign country)
N. Y. N.Y. | |
| 13. FATHER'S NAME
Charles Underwood (Deceased) | | | 14. MOTHER'S MAIDEN NAME
Lola Nolan (Deceased) | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
534-28-67-16 | | 17. INFORMANT Address
VA Hospital Records - Perry Point, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO (b) coronary occlusion
DUE TO (c) Arteriosclerotic heart disease, severe | | | | | INTERVAL BETWEEN ONSET AND DEATH
4-7 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that 4 (this hospital) attended the deceased from 2 19 62 , 19 62 to 9 24 67 , 19 67 , and that death occurred at 3:50 P.M., from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
A.L. Mooney | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
9 25 67 |
| 22c. PHYSICIAN'S NAME (Type)
A. L. MOONEY | | | 22d. ADDRESS
VA Hospital - Perry Point, Maryland | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
SEPT 27 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln - Wash D.C. | 23d. LOCATION (City or Town) (County) (State)
BLADENS BURG, MARYLAND | | |
| 24. FUNERAL DIRECTOR ADDRESS
CHAMBERS FUNERAL HOME - Riverdale, Maryland | | | 25a. REC'D BY REGISTRAR
DATE SEP 27 1967 | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

M

Local

Henry Ford

W. Hospital

Name White

Address

Birth as shown on

Yes No

Training

(Occupation)

194-2-27-10 W. Hospital - Henry Ford, Maryland

Education

Special Education: none, severe

DENS

194-2-27-10 W. Hospital - Henry Ford, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 1/64
25M 1/64

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12323

CERTIFICATE OF DEATH

12333

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Cecil
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point | | c. LENGTH OF STAY IN 1b
1 day | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VA Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Alson Middle Paul Last WADDELL | | 4. DATE OF DEATH
Month 9 - Day 25 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4-15-96 |
| 9. AGE (In years last birthday) yrs. 71 | | 10. IF UNDER 1 YEAR
Months 11 Days 10 Hours 10 Min. 10 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter Ret. | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction Co. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Grassy Creek, N.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William Waddell (Deceased) | | 14. MOTHER'S MAIDEN NAME
Martha Richardson (Deceased) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
218-03-04-36 | |
| 17. INFORMANT
VA Hospital Records - Perry Point, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease
DUE TO
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Chronic pulmonary emphysema | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (this hospital) attended the deceased from Sept. 25, 1967 to Sept. 25, 1967 , that the deceased died on Sept. 25, 1967 , and that death occurred at 4:00 p.m. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
A. L. Mooney | | 22b. DATE SIGNED
9-26-67 | |
| 22c. PHYSICIAN'S NAME (Type)
A. L. MOONEY, M.D. | | 22d. ADDRESS
VA Hospital - Perry Point, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
9-28-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Conowingo Baptist Cemetery | 23d. LOCATION (City or Town) (County) (State)
Conowingo, Maryland |
| 24. FUNERAL DIRECTOR
TYSON FUNERAL HOME - Rising Sun, Md. | | 25a. REC'D BY REGISTRAR
SEP 29 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12334

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|--|--------------------|--|--------------------------|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) /
a. STATE Del. b. COUNTY New Castle | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. LENGTH OF STAY IN 1b D.O.A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Wayne David Wallace | | 4. DATE OF DEATH 9 23 19 67 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-13-67 |
| 9. AGE (In years last birthday) yrs. 7 10 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 11b. KIND OF BUSINESS OR INDUSTRY None | |
| 12. BIRTHPLACE (State or foreign country) Del. | | 13. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14. FATHER'S NAME Unk. | | 15. MOTHER'S MAIDEN NAME Sandra Lee Wallace | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 17. SOCIAL SECURITY NO. None | |
| 18. INFORMANT Sandra L. Wallace, 62 Maple Dr, Newark, Del. | | Address | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
9240 IMMEDIATE CAUSE (a) Asphyxia
DUE TO (b) Rubber pants over face.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) Rubber baby pants fell over face in crib. | |
| 21a. TIME OF INJURY Month, Day, Year 5:51 p.m. 9-23 19 67 | | 21b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 21d. (City or town) (County) (State) Newark, New Castle, Del. | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John M. Byers | | 23. DATE SIGNED 9-23-67 | |
| EXAMINER'S NAME (Type) John M. Byers, M.D. | | 24. ADDRESS Elkton, Md. | |
| 25a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 25b. DATE THEREOF 9-26-67 | |
| 25c. NAME OF CEMETERY OR CREMATORY Silverbrook Cemetery | | 25d. LOCATION (City or Town) (County) (State) Wilmington N.C. Dela. | |
| 26. FUNERAL DIRECTOR William J. Narwick | | 27. ADDRESS Newark, Dela. | |
| 28. REC'D BY REGISTRAR | | 29. REGISTRAR'S SIGNATURE | |
| DATE SEP 26 1967 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12325

CERTIFICATE OF DEATH

12335

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|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rising Sun Rural | | c. LENGTH OF STAY IN 1b
Life | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rising Sun Rural | | 07.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Melvin Bond White | | 4. DATE OF DEATH Sept. 6 1967 | |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-20-1910 | |
| 9. AGE (In years lost birthday) yrs. 57 | | 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Labor Ret. | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction Co. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland Cecil Co. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William W. White | | 14. MOTHER'S MAIDEN NAME
Viola Jones | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-05-3066 | |
| 17. INFORMANT
Mrs. Melvin White | | Address
Rising Sun, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) 5271
DUE TO Chronic Emphysema
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO Prolonged Tobacco Use
(b) 39
(c) | | INTERVAL BETWEEN ONSET AND DEATH
39 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
0021 | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6-6 , 19 67 , to 9-6 , 19 67 , that (I) (we) last saw the deceased alive on 8-29 , 19 67 , and that death occurred at 9:30 A.M. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
G.H. Richards | | 22b. DATE SIGNED
9/8/67 | |
| 22c. PHYSICIAN'S NAME (Type)
G.H. Richards | | 22d. ADDRESS
Port Deposit Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9-9-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Hopewell Cem. | | 23d. LOCATION (City or Town) (County) (State)
Port Deposit Cecil Md. | |
| 24. FUNERAL DIRECTOR
Ernest E. Fuller | | 25a. REC'D BY REGISTRAR
SEP 11 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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OFFICE OF THE ATTORNEY GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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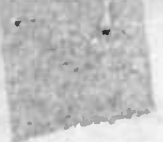
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12326

CERTIFICATE OF DEATH

12336

| | | | |
|---|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Cecil
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Pennsylvania
b. COUNTY
Philadelphia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point | | c. LENGTH OF STAY IN 1b
22 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | e. STREET ADDRESS
1185 Morefield Road | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
ALBERT F. WIDMANN | | 4. DATE OF DEATH
Month Day Year
September 6 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-26-95 |
| 9. AGE (In years last birthday) yrs.
72 | | 10. IF UNDER 1 YEAR
Months Days Hours Min.
7 2 0 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Philadelphia, Pa. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Frank Widmann | | 14. MOTHER'S MAIDEN NAME
Mary Kessler | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
088-09-4385 | |
| 17. INFORMANT
VA Hospital Records, Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral
DUE TO (b) Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Arteriosclerosis, Generalized
years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Cerebral arteriosclerosis | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (A) (this hospital) attended the deceased from Aug. 15 , 19 67 , to Sept. 6 , 19 67 , and that death occurred on Sept. 6, 1967 , at 7:30 M. from causes on the date stated above. | | | |
| 22a. SIGNATURE
A. L. Mooney | | 22b. DATE SIGNED
9-6-67 | |
| 22c. PHYSICIAN'S NAME (Type)
A. L. MOONEY, M.D. | | 22d. ADDRESS
VAH, Perry Point, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9-9-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Shoot's Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Dauphin County, Harrisburg, Pa. | |
| 24. FUNERAL DIRECTOR
Patterson Funeral Home, Perryville, Md. for Zimmerman Funeral Home, Harrisburg, Pa. | | 25a. REC'D BY REGISTRAR
DATE SEP 11 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles J. J... | | | |



Pennsylvania

Genie

Philadelphia

22 days

Army Point

1155 Moreland Road

Veterans Administration Hospital

2

A

September

WILMINGTON

1.

ALBERT

X

72

7-28-98

White

Male

U.S.A.

Philadelphia, Pa.

Retired

Army Hospital

Franklin

VA Hospital Records, Army Point, Md.

088-02-1288

W 1

Yes

7-10 days

Brachycephalic, bilateral

Arteriosclerotic heart disease

years

Arteriosclerotic, generalized

X

Cerebral arteriosclerosis

02 XXXX XXXX

02 Sept. 6

07

12 Aug. 12

2:30

XXXXXXXXXXXXXXXXXXXX

75-5-57

X

VAH, Army Point, Md.

A. L. MOORE, M.D.

General (Army Point, Md.)

Shaw's (Army Point)

General

Interpretation of records, Army Point, Md. for

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12327

CERTIFICATE OF DEATH

12337

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>CECIL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>CECIL</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>HOLLYWOOD BEACH</u> | | c. LENGTH OF STAY IN lb
<u>18 YRS</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>—</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>HOLLYWOOD BEACH</u> 07.1 | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | d. STREET ADDRESS
<u>—</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>ROLAND</u> First <u>H.</u> Middle <u>Wilson</u> Last | | 4. DATE OF DEATH
Month <u>Sept</u> Day <u>28</u> Year <u>1967</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>AUG. 24, 1901</u> 66 |
| 9. AGE (In years last birthday)
<u>66</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>BELL TELEPHONE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>PHONE</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>PHILA. PA</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>USA</u> | |
| 13. FATHER'S NAME
<u>HARPER WILSON</u> | | 14. MOTHER'S MAIDEN NAME
<u>CATHERINE ROLAND</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>163-01-0747</u> | |
| 17. INFORMANT
<u>VIOLET M. WILSON - CHES CITY, MD</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>
<u>4200</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>—</u> DUE TO
(c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Bilateral pneumonia Residuals of Previous CVA</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>—</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>17 Sept, 1967</u> to <u>28 Sept, 1967</u> that (I) (we) last saw the deceased alive on <u>28 Sept 67</u> , and that death occurred at <u>7 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Wallaxe Obenshain</u> M.D. | | 22b. DATE SIGNED
<u>2 Oct 67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Wallaxe Obenshain, MD.</u> | | 22d. ADDRESS
<u>Cecilton, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>10/3/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>St JOHNS V. B.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>PARADISE PA</u> | |
| 24. FUNERAL DIRECTOR
<u>PIPPIN FUNERAL HOME</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| ADDRESS
<u>ELKTON, Md</u> | | DATE
<u>OCT 3 1967</u> | |



RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535
JUN 10 1964



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | |
|--|--|-----------------------------------|---------------------------|--|---|--------------------------------|-------------------------------------|--|--|--|
| 12328 | | | | | | | | | | |
| 12338 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| Reg. Dist. No. | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md. b. COUNTY Cecil | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warrick | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | | | | d. STREET ADDRESS | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mary Woolford | | | | | 4. DATE OF DEATH Month Sept. 8 Year 19 67 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 5, 1901 | | 9. AGE (In years last birthday) 66 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME James Wanamaker | | | | | 14. MOTHER'S MAIDEN NAME Lucy Duker | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | | | 16. SOCIAL SECURITY NO. 221-14-3959 | | | | | |
| | | | | | INFORMANT Address Audrey Knight- Warrick Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus
Coronary occlusion with massive anterior infarction
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | | | | | | | | |
| 21. I certify that I attended the deceased from 5 Sept 67 ¹⁹ to 9 Sept 67 ¹⁹ , that I last saw the deceased alive on 9 Sept 67 ¹⁹ , and that death occurred at 3 PM from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Cecilton Md.
DATE SIGNED 12 Sept 67
ACTUAL SIGNATURE Wallace Obenshain
PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D. Cecilton, Md. | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 22b. DATE THEREOF 9/16/67 | | 22c. NAME OF CEMETERY OR CREMATORY Dale Cem. | | | 22d. LOCATION (City, town, or county) (State) Middletown, Del. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John R. Bell | | | | | ADDRESS 909 Poplar St. | | 24a. REC'D BY REGISTRAR SEP 14 1967 | | 24b. REGISTRAR'S SIGNATURE J Charles Judge | |



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